STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner **File No. 120761-001**

v

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this _12th_ day of September 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On April 21, 2011, XXXXX, on behalf of his minor son XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. The Commissioner reviewed the request and accepted it on April 28, 2011.

The issue in this external review can be decided by a contractual analysis. The contract here is Blue Cross Blue Shield of Michigan's *Community Blue Group Benefits Certificate* (the certificate). The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

On December 9, 2010, the Petitioner received emergency care from Dr. XXXXX, at XXXXX Medical Center near his home in XXXXX. This facility participates with the local Blue Cross Blue Shield plan but Dr. XXXXX does not. Dr. XXXXX's charges totaled $4,223. Blue Cross Blue Shield of Michigan (BCBSM) paid its approved amount of $658.79, leaving the Petitioner's parents responsible for the balance of $3,564.21.

The amounts charged for the Petitioner's care provided by Dr. XXXXX and the amounts paid by BCBSM are presented in the table below:

Procedure Code	Nomenclature	Amount Charged	Approved Amount Paid by BCBSM	Balance
13121	Surgery-Repair of Wound or Lesion	$3,473.00	$497.60	$2,975.40
99243	Consultation	$750.00	$161.19	$588.81
Total		$4,223.00	$658.79	$3,564.21

The Petitioner's father appealed BCBSM's payment amount through its internal grievance process. BCBSM held a managerial-level conference on March 9, 2011, and issued a final adverse determination dated March 31, 2011.

III. ISSUE

Is BCBSM required to pay an additional amount for the Petitioner's December 9, 2010, care provided by Dr. XXXXX?

IV. ANALYSIS

Petitioner's Argument

On December 9, 2010, the Petitioner severely cut his left elbow on a broken glass. The Petitioner's father followed the directions on the BCBSM website for treatment and took the Petitioner to his pediatrician who is a PPO doctor. The pediatrician immediately instructed him to go to XXXXX Medical Center emergency room for stitches. This facility is also a PPO provider. At the emergency room, the Petitioner had no choice of surgeons and Dr. XXXXX was the on-call doctor available.

The Petitioner believes that BCBSM is required to pay significantly more for the services provided by Dr. XXXXX.

BCBSM's Argument

BCBSM states that the certificate (p. 4.2) provides that BCBSM's payment is based on an "approved amount" for covered services. The certificate does not guarantee that charges will be paid in full even if the care is provided for an emergency condition.

To determine its payment level for each service, BCBSM applies a resource based relative value screen scale (RBRVS). This is a nationally recognized reimbursement structure developed by and for physicians. The RBRVS reflects the resources required to perform each

service, including physician time, specialty training, malpractice premiums, and practice overhead. BCBSM regularly reviews the ranking of procedures to address the effects of changing technology, training and medical practice.

BCBSM states its approved amount is the same for both participating and nonparticipating providers. Participating providers have entered into a contractual agreement with BCBSM to accept the approved amount as payment in full for covered services provided to BCBSM members. However, nonparticipating providers have no contractual obligation to accept the approved amount as payment in full and may bill a BCBSM member for any balance over BCBSM's approved amount.

BCBSM understands that the Petitioner feels he had no choice in which provider to use. However, there is nothing in the certificate language that requires BCBSM to pay more than its approved amount for these services even if the care was provided on an emergency basis or no participating provider was available.

Commissioner's Review

Under the Petitioner's health care plan, enrollees incur the least out-of-pocket cost if they receive services from providers who participate with BCBSM. "Nonparticipating provider" is defined in the certificate as:

> Physicians and other health care professionals, or hospitals and other facilities or programs that have not signed a participation agreement with BCBSM to accept the approved amount as payment in full. Some nonparticipating providers, however, may agree to accept the approved amount on a per claim basis.

The certificate (page 4.33) explains the consequences when enrollees use nonparticipating providers:

> If the nonpanel provider is **nonparticipating**, you will need to pay most of the charges yourself. Your bill could be substantial. . . .
>
> * * *
>
> **NOTE:** Because nonparticipating providers often charge more than our maximum payment level, our payment to you may be less than the amount charged by the provider.

The certificate describes how benefits are paid when services are received from a nonparticipating provider, such as Dr. XXXXX. BCBSM pays only its approved amount for covered services. The certificate does not guarantee that the nonparticipating provider's charge will be paid in full. "Approved amount" is defined in the certificate as BCBSM's maximum payment level or the provider's charge for the covered service, whichever is lower. As a

nonparticipating provider, Dr. XXXXX is not bound to accept BCBSM's approved amount as payment in full for his services and he may bill the Petitioner for any difference between his charge and BCBSM's approved amount.

The Commissioner concludes that BCBSM covered Dr. XXXXX's services correctly under the terms and conditions of the certificate.

V. ORDER

BCBSM's final adverse determination of March 31, 2011, is upheld. BCBSM is not required to pay any additional amount for the care Petitioner received from Dr. XXXXX on December 9, 2010.

This is a final decision of an administrative agency. Under MCL 550.1915(1), any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

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R. Kevin Clinton
Commissioner